

Washington State Nursing Care Quality Assurance Commission  
Practice Guidelines for Telehealth/Telenursing For Registered Nurses

1. Telephone triage and nursing consultation by telephone or other electronic technology, incorporates unique knowledge, skill and competencies. Nurses employ the full range of the nursing process to gather data, make assessments, and generate plans for care via telephone encounters with patients.
2. Protocols are appropriate tools for implementing treatment plans. A registered nurse may use a protocol that has been written and approved by a physician to initiate a standing order for a medication or treatment. Assuming an appropriate patient-prescriber relationship exists, authorized standing orders may be implemented without consulting an authorized prescriber for a particular patient.

The registered nurse should implement only standing orders which include a target population, exclusions, the population served, contraindications, special considerations, a specific order, a description of who has the authority to implement the order, physician signature, and review and approval by nursing as well as other involved disciplines.

3. Practice guidelines and protocols for care should be developed based on scientific/empirical evidence and outcomes data or expert opinion. Methods for periodic review of these tools to evaluate care effectiveness and currency of information should be in place.
4. Practice guidelines should evolve through collaboration and professional consensus among all involved health care disciplines.
5. When functions of the nurse involve complex decision making, even when driven by algorithm and protocol, telenursing should be limited to the practice of registered nursing. Licensed practical nursing activities within this context may include information gathering and the provision of patient education.
6. The registered nurse must be able to access a provider licensed to prescribe if questions or issues arise related to the order or the telephone encounter.
7. Documentation of patient encounters must include a record of the patient's statements and symptoms, recommendations for care management with reference to the specific protocol or guideline, timely communication with other health care providers if indicated, and confidentiality of clinical information. Documentation in the patient's permanent record should occur as soon as is reasonably possible.